MEDCHI'S PROPOSED RECOMMENDATIONS TO GOVERNOR'S TASK FORCE ON HEALTH CARE ACCESS AND REIMBURSEMENT

<u>Recommendation No 1:</u> Establish a five-year loan forgiveness program for medical school debts to any graduate of an American medical school who agrees to practice primary care in a Maryland shortage area. Debt will be remitted at the rate of 20% per year until extinguished. This program would be complimentary and coordinated with the existing LARP program but, in the end, the goal would be to locate primary care physicians in Maryland (not federal) defined shortage areas with a complete five-year payback program. Eligible primary care physicians would include those who are board certified and who have completed residency in family practice, OB-Gyn, internal medicine, pediatrics or general psychiatry.

The Following Information Is Excerpted From One Report of a Separate Task Force to Review Physician Shortages In Rural Areas:

- Establish/expand loan forgiveness programs targeted at "shortage areas."

  <u>Rationale</u>: Need to have multiple recruitment mechanisms when average debt of a medical school graduate is $147,000 and Maryland is a low reimbursement, high-cost of living state.

  The current program is only available for primary/mental health care and only if the physician is practicing in a nonprofit setting in a federally designated shortage area.

- Allow other "nonprofit" organizations, *such as hospitals, nursing homes, clinics, hospices, etc.*, to sponsor a physician for loan assistance reimbursement program (LARP) purposes but also includes "for profit" organizations such as a physician's private practice to qualify.

  <u>Rationale</u>: Requiring the physician to wok in a "nonprofit setting" limits recruitment efforts by private physicians in shortage areas. *Allowing a nonprofit to "sponsor" the physician and permit the physician to work in a private practice setting would greatly expand the opportunities for retaining the physician in that community on a long term basis.*

- Adjust the current assessment on physician licenses to expand LARP.

  <u>Rationale</u>: *Currently, 14% of the physician license fees are dedicated and split between two programs: 1) grants under the Health Manpower Shortage Incentive Grant Program; and 2) the Loan Assistance Repayment Program for primary care physicians. For FY 2008 the grants awarded under the Health Manpower Shortage Incentive Grant Program totaled $499,098 and were split between 39 different postsecondary institutions. The LARP for primary care physicians in FY*

2008 totaled $432,500, with an average of $25,441 provided to 17 physicians.

Generating additional revenue for the state portion of LARP funding could be used to draw down additional federal funding and/or establish a state program with greater flexibility. *Further discussion may also be warranted to determine whether the grants awarded under the Health Manpower Incentive Grant Program are too small/diluted to have the impact originally intended.*

- Allow hospitals in shortage areas to establish loan forgiveness approaches under the all-payer system in exchange for a commitment to practice in the shortage area – similar to the Nurse Support Programs I and II.

  Rationale: Generating additional revenue *from all payers* for the state portion of LARP funding could be used to draw down additional federal funding and/or establish a state program with greater flexibility.

- Aggressively pursue additional HPSA/MUA designations for Maryland through the Office of Primary Care.

  Rationale: Locations or population groups that meet the criteria for federal designation are eligible for more than 30 federal program resources and benefits.

- Create a Maryland Health Service Corps program for all Maryland shortage areas.

  Rationale: Shortages exist in areas and specialties in Maryland beyond the limited focus of the national program.

Recommendation No 2: Change Maryland's current statutory formula applicable to non-participating physicians treating HMO patients to Colorado law where the "balance" of a non-participating doctor's bill is paid by the HMO not by the patient.

Rationale: Maryland's current statutory formula requires an HMO to pay a non-par doctor the "greater of" 125% of the rate that the HMO pays in the same geographic area to a similarly licensed provider under written contract with the HMO or the rate that the HMO paid as of January 1, 2000. Health General Article §19-710.1(b). The Maryland Insurance Administration (MIA) has ratified the practices of most HMOs which are to pay the 125% of the lowest rate paid to a similarly licensed provider. The only court to ever consider the issue was the Circuit Court of Anne Arundel County which ruled that HMOs must pay 125% of the "average" paid by the HMO to similarly licensed providers. The Anne Arundel County case is known as Delmar Emergency Specialists, et al. v. MD-IPA et al. (Civil Case No.: 02-C-05-110040IT) and the ruling was by Judge Paul Hackner (Order attached to hard copy of this letter). After being advised of Judge Hackner's decision, the MIA refused to reconsider its position (Birrane letter of April 9, 2007 attached to hard copy of this letter).

MedChi believes that the proper reading of the statute is that the "average" rate should be the basis for the 125% multiplication. However, neither the "lowest" or the "average" rate remedies the problem with the current statutory formula because the rates are not transparent. Each company has different contractual rates. The use of a transparent standard such as the Medicare fee schedule would be the easiest to administer but, unfortunately, certain specialties (particularly anesthesiology) are adversely impacted by the use of Medicare fees. Perhaps a compromise would be to use the Medicare fee schedule for most specialties and maintain a variant of the present system (125% of average) for those specialties for which Medicare is inappropriate.

One method to enforce the "average" calculation would be to amend Insurance Article 15-113 which requires "carriers" (including HMOs) to provide a health care practitioner with a written copy of a schedule of applicable fees for up to the 50 services billed by a health care practitioner in that specialty.

MedChi believes, however, that the cleanest method would be to adopt the law of Colorado which requires the HMO to be responsible for the "balance" of any doctor's bill. In most cases, hospital based doctors are being pressured by hospital administrators to sign contracts and will do so if the reimbursement offered is appropriate. Moreover, HMOs are required to have "adequate" networks so that a patient is not sent to a "participating" doctor where there are no participating doctors. Many advantages accrue to doctors who "participate" but there will be no incentive to enter into contracts as long as HMOs are able to manipulate the payment to non-par doctors with respect to their HMO patients.

<u>Recommendation No. 3</u>: Require carriers to reimburse PCPs a premium for visits after the 5:00 p.m. workday and, on weekends and to provide a compensation schedule to PCPs for phone and e-visit communications delivered to a patient.

<u>Rationale:</u> At the present time, most primary care doctors are not additionally compensated for night time office visits or for telephone and email communications with patients. As email has expanded throughout American life, there is no reason that a doctor should not be able to interact with a patient by use of this medium or by use of the telephone. Such communication can "save" an office visit for a patient who is unable to accommodate an inpatient visit into their schedule.

The potential dollar savings are dramatic. For instance, a primary care doctor in Maryland is paid approximately $37 per office visit whether that office visit occurs during the normal business hours or after hours. Since the doctor is paid no more for nighttime visits, a referral is often made to the Emergency Department for a patient who feels that they need to be examined. The Emergency Department visit will typically cost between $135 and $150 with an expected long wait. Paying a primary care doctor double his or her office visit rate for a nighttime visit ($74) would result in significant savings as well as greater convenience to the patient.

<u>Recommendation No. 4</u>: The enactment of medical malpractice reforms consistent with the laws of California and Texas.

Rationale: California and Texas are two states which provide a favorable environment for physicians. The California MICRA law has been in effect since the early 1980s and results in significantly reduced premiums for medical malpractice insurance. Texas, on the other hand, saw a crushing rise in malpractice premiums until it enacted reforms a few years ago. The result of those reforms: significant reductions in malpractice premiums and a flood of doctors seeking to practice in Texas.

The "canary in the mine" for the malpractice environment is the rate charged to an OB-Gyn. The Maryland OB-Gyn rate is so high that it not only indicates that Maryland is a toxic malpractice environment but has resulted in the early retirements or abandonment of OB practices by numerous doctors. Real reform can reduce the Maryland OB-Gyn rate to that of California or Texas. According to the Medical Liability Moniter (October 2007, Vol. 32, No. 10) the average 2007 manual rate for OB-Gyns (exclusive of all credits and dividends) in Maryland was $133,117 as opposed to the California figure of $62,892 and the Texas figure of $83,678.

The reduction of the OB-Gyn rate will mean that <u>all rates</u> have come into line.

<u>Recommendation No. 5</u>: Establishment of a primary care demonstration project under the auspices of the Maryland Health Care Commission with health insurer support of primary care practices with increased E and M fees for doctors who take part in a "medical home" practice. Med Pac, the congressional think tank, has proposed increased payment for Medicare E and M codes to those practices which are "primary care" with the notion being that primary care doctors can address medical problems that may otherwise be referred to specialists because of inadequate reimbursements.

<u>Rationale</u>: The Governor's newly established Quality and Cost Council should create a uniform statewide approach with equitable funding, to assist physicians to establish patient centered medical homes. Providing information technology improvement funding, similar to the current CMS demonstration now under way, would eliminate a huge barrier in making these investments, will enhance quality improvement and patient safety initiatives and may create leverage for additional federal funding under the CMS Medical Home Demonstration Project. **It is critical that this demonstration project identify the true cost for a medical home practice and develop a proper level of reimbursement so that a primary care doctor can be financially successful.**

A state sponsored demonstration project may well provide a pathway to recognize both an increased role and increased reimbursement for primary care physicians. Increased reimbursement is critical to retaining and recruiting such physicians.

<u>Recommendation No. 6</u>: A pilot project under the auspices of the Maryland Healthcare Commission for volunteer Emergency Departments to come under the current "all payer" system and to have this system apply to reimbursement of the covered Emergency Department practice.

<u>Rationale:</u> The Maryland Hospital All-Payer System is a model for fair reimbursement. The reimbursement levels are set by independent state agencies and are required to be reimbursed by "all payers."

Maryland presents a case study in inequitable bargaining power between health insurance carriers and physicians. Maryland physician practices tend to be small and two insurance carriers control perhaps 80% of the market. It seems reasonable to conduct a pilot project to see whether a hospital based physician specialty could be integrated into the current system at a particular hospital.

Some have suggested that Medicare would not be supportive of the inclusion of hospital based physician practices. However, when the hospital rate commission was first established it asserted jurisdiction over all hospital based physician practices only to lose its assertion of jurisdiction in a number of court decisions. Even at the present time, two emergency departments are subject to HSCRC jurisdiction (the Chester River Hospital in Kent County and the McCready Hospital in Crisfield). Hence, to the degree two of our state's emergency departments are already covered by current Medicare waiver; it may be that Medicare would look favorably on a pilot project.

<u>Recommendation No. 7</u>: MedChi supports many of the recommendations and proposals contained in the SAGE presentation which is being presented to this Task Force on Monday, October 6th, particularly those designed to encourage the creation of private physician practices in Maryland.